Review of: "Inpatient psychiatry unit devoted to COVID-19 patients"

Eyal Kedar

Potential competing interests: The author(s) declared that no potential competing interests exist.

I found this to be a useful but still rudimentary blueprint for developing an inpatient psychiatric unit (IPU) for COVID-19 patients. In order for this to serve as a realistic template for other hospitals and health systems seeking to develop a covid IPU, there are a number of additional details that will need to be provided. Some of my key questions and comments are:

Are the protocols described in section 3.6 further detailed in a supplementary appendix? If not, this would be a very useful addition to this article.

Did you observe any patient on patient violence? If so, what were your protocols for preventing and handling this?

What was your protocol for handling violent patient activity in general?

Do you think this model could be replicated in rural and other areas with decreased medical resources? If so, how?

What was your specific protocol for administering psychiatric medications to those patients who refused them? (section 3.13)

You note that patients could not be observed directly in their rooms (section 3.14). In designing a better system for inpatient psychiatric care delivery for COVID-19 pts, which design flaws in your current system would you fix and how?

Was hospital clergy involved in this care delivery system? If not, would it be possible to have clergy involved (even if just virtually) in an improved version of a covid IPU?

What was your discharge strategy for patients with resolved covid who were not psychiatrically stable for home discharge? How did you prevent your beds from being taken up by patients who were challenging to discharge after they had recovered from COVID-19?

For those patients with newly diagnosed psychiatric disease, what kind of plan did you have for transitioning them to outpatient psychiatric care after discharge?

You note in section 3.18 that "the unit maintained adequate staffing to ensure safety and limit stress." What exactly was your staff to patient ratio in this IPU? Though it sounds as if your plan to limit burnout succeeded in the short term, did you experience staff burnout and attrition later in the pandemic?

In summary, I think that this article is an important addition to the growing body of literature on structuring future responses to COVID-19 and other pandemics. I also think, however, that this article will need to be expanded significantly (either in a follow-up article or through a supplementary appendix to this one) if the authors hope to increase its relevance for physicians and administrators who hope to develop their own covid IPU.